Child Fatality Review #08-06
Region 4
King County

This nine-month-old African American female died of compressional asphyxiation.

Case Overview

On February 4, 2008, the King County Medical Examiner reported to Children's Administration (CA) the death of this nine-month-old child. The Medical Examiner reported the deceased child and her mother slept in the same bed that consisted of a mattress and box springs without a bed frame. This bed was pulled away from the wall and away from a heater to allow for circulation. The mother reported she and her daughter went to bed around 10:30 p.m. The mother reported she woke up when her brother came into her room shortly before midnight and asked her where the baby was. The mother found the deceased child face down (prone) in the gap between the wall and the head of the bed. The baby was lying on top of a pillow that had fallen down in the gap. The Medical Examiner determined that the cause of death was compressional asphyxia. The Medical Examiner determined the manner of death was accidental, but there were also several risk factors that may have contributed to this child's death including cigarette smoke in the home environment and the baby co-sleeping with her mother on a soft surface.

Referral History

There are 18 referrals to Child Protective Services (CPS) intake on this family prior to the birth of the deceased child. The first referral was reported in February 1997. Four of the referrals alleged lack of parental supervision of the oldest brother. Several of the referrals were called in by school personnel on the same boy (the deceased child's older brother) alleging he had frequent poor attendance and had poor hygiene when he did attend school. There are three referrals that alleged the deceased child's mother assaulted non-family members and all were screened out as 3rd party. One referral alleged domestic violence between the mother and a former boyfriend. Two referrals alleged substance abuse by the mother, including information that she attended, but did not complete, inpatient drug/alcohol treatment. Six of the 18 referrals were investigated by Child Protective Services (CPS) or opened for services. None were closed with a founded finding. Three referrals alleged the oldest brother ran away from home and was caught trespassing on private property. This same child was placed in foster care under a Voluntary Placement Agreement (VPA). These referrals were accepted for Family Reconciliation Service (FRS). The brother ran from his foster care placement.

On January 28, 2008, CPS intake received a referral from law enforcement reported they were placing the deceased child's brother in protective custody for runaway and taking him to the SCRC. The deceased child's mother was charged with selling property her son had

stolen. The brother threatened to assault the assigned FRS social worker and also stole from a staff member at Spruce Street. He was placed in foster care, but ran away from this placement. This referral was screened accepted for FRS. The FRS social worker met with the deceased child, her brother, mother and grandmother. The mother's newborn infant (the deceased child) seemed healthy and normal. The social worker went to the home with a Chemical Dependency Professional (CDP) who screened the mother to determine her need for further treatment.

On February 4, 2008, CPS intake was informed of the deceased child's death the day before. The Medical Examiner determined the manner of death was accidental, but there were also several risk factors that may have contributed to the child's death. There was cigarette smoke in the environment; the infant co-slept with her mother on a soft surface (adult pillow and adult mattress), and there was a gap between the wall and the mattress into which the baby slipped, head-first. The mother's state of impairment, if any, was unknown. This referral was accepted for investigation by CPS but closed without a finding.

Issues and Recommendations

Issue: There were no referrals from the hospital, or other health care providers, concerning the mother's pregnancy or the deceased child's birth. A CPS social worker did make an information only report to intake about the mother's pregnancy, but the case was closed before the deceased child was born. The mother entered inpatient treatment for severe cocaine dependence when she was eight months pregnant, and left after eight weeks, against the treatment plan. She did seek WIC formula and as a result received Maternal Support Services (MSS) from Public Health Nursing.

Recommendation: The Program Manager will discuss mandatory reporting with the DSHS Division of Alcohol and Substance Abuse (DASA).

Issue: The death scene investigation. While it is usually the medical examiner who reports child deaths to CPS, law enforcement typically arrives first. A call from law enforcement to CPS intake could have provided them with more information about the mother, including substance abuse issues. That may have led to information about whether she had been using drugs or alcohol.

Recommendation: Follow the CPOD Guidelines for First Responders: Child Deaths and Serious Physical Injury Cases (Collaboration, Preservation, Observation and Documentation), produced in 2006 by the Washington State Criminal Justice Training Commission.